(d) *State plan specifications.* For each charge imposed under this section, the plan must specify—

(1) The service for which the charge is made;

(2) The amount of the charge;

(3) The basis for determining the charge;

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 67 FR 41116, June 14, 2002; 75 FR 30261, May 28, 2010]

EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, § 447.53 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 447.53 Cost sharing for drugs.

(a) The agency may establish differential cost sharing for preferred and non-preferred drugs. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (d) of this section. All drugs will be considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs.

(b) At state option, cost sharing for drugs may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment. Such increase shall not be applied to any cost sharing that is based on the amount the agency pays for the service):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Preferred Drugs	$4	$4.
Non-Preferred Drugs	8	20% of the cost the agency pays.

(c) In states that do not have fee-for-service payment rates, cost sharing for prescription drugs imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 150 percent of the FPL in paragraph (b) of this section.

(d) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in paragraph (b) of this section.

(e) In the case of a drug that is identified by the agency as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a timely process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

§ 447.54 Maximum allowable and nominal charges.

Except as provided at §§ 447.62 through 447.82 of this part, the following requirements must be met:

(a) *Non-institutional services.* Except as specified in paragraph (b) of this section, for non-institutional services, the plan must provide that the following requirements are met:

(1) For Federal FY 2009, any deductible it imposes does not exceed $2.30 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 6-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $13.80. In succeeding years, any deductible may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component

of the CPI–U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3)(i) For Federal FY 2009, any copayments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

State payment for the service	Maximum copayment
$10 or less	$0.60
$10.01 to $25	1.15
$25.01 to $50	2.30
$50.01 or more	3.40

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(4) For Federal FY 2009, any copayment that the State imposes for services provided by a managed care organization (MCO) may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system. When there is no fee-for-service delivery system, the copayment may not exceed $3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and §431.57 of this chapter, for nonemergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, §447.54 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 447.54 Cost sharing for services furnished in a hospital emergency department.

(a) The agency may impose cost sharing for non-emergency services provided in a hospital emergency department. The provisions in §447.56(a) shall apply except as the agency exercises the option under paragraph (c) of this section.

(b) At state option, cost sharing for nonemergency services provided in an emergency department may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing identified for individuals with family income at or below 150 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Non-emergency Use of the Emergency Department	$8	No Limit.

(c) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-emergency use of the emergency department, not to exceed the maximum amount established in paragraph (b) of this section for individuals with income at or below 150 percent of the FPL.

(d) For the agency to impose cost sharing under paragraph (a) or (c) of this section for non-emergency use of the emergency department, the hospital providing the care must—

(1) Conduct an appropriate medical screening under § 489.24 subpart G to determine that the individual does not need emergency services.

(2) Before providing non-emergency services and imposing cost sharing for such services:

(i) Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

(ii) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(iii) Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

(iv) Provide a referral to coordinate scheduling for treatment by the alternative provider.

(e) Nothing in this section shall be construed to:

(1) Limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (c) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard copayment of $.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

[43 FR 45253, Sept. 29, 1978, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, § 447.55 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 447.55 Premiums.

(a) The agency may impose premiums upon individuals whose income exceeds 150 percent of the FPL, subject to the exemptions set forth in § 447.56(a) and the aggregate limitations set forth in § 447.56(f) of this part, except that:

(1) Pregnant women described in described in paragraph (a)(1)(ii) of this section may be charged premiums that do not exceed 10 percent of the amount by which their family income exceeds 150 percent of the FPL after deducting expenses for care of a dependent child.

(i) The agency may use state or local funds available under other programs for payment of a premium for such pregnant women. Such funds shall not be counted as income to the individual for whom such payment is made.

(ii) Pregnant women described in this clause include pregnant women eligible for Medicaid under § 435.116 of this chapter whose income exceeds the higher of –

(A) 150 percent FPL; and

(B) If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(2) Individuals provided medical assistance only under sections 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), may be charged premiums on a sliding scale based on income.

(3) Disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act, may be charged premiums on a sliding scale based on income. The aggregate amount of the child's premium imposed under this paragraph and any premium that